When the Mailman Can't Find You

How the DMHDD Is Helping the Homeless

PATH

The night is cold, somewhat blustery. Your breath materializes as you exhale each gulp of air taken in through your lips. Walking from the car to the warm, cozy restaurant, you pass a man adorned with a coat of rags. His eyes glance up at you. They appear to reach out, like a child's arms at Christmas. Do you give him a second thought before going in to meet your friends?

It has been estimated that 600,000 individuals are homeless in the United States. Of these, about one-third are adults with serious mental illnesses.

In 1990, the Stewart B. McKinney Homeless Assistance Amendments Act authorized a federal grant program to deal with the needs of the homeless who have serious mental illnesses. The program, Projects for Assistance in Transition from Homelessness (PATH), funds community-based outreach, mental health, substance abuse, case management and other support services. It also offers a limited set of housing services.

Homeless persons face barriers to accessing, utilizing and succeeding in mainstream mental health systems. These include a lack of income verification documents, difficulties maintaining schedules and a lack of transportation. On top of that, many mainstream mental health service providers are ill prepared to handle complex social and health conditions that the homeless population presents.

The PATH program attempts to cover some of these basic needs. With federal monies, states award funds to community-based organizations for delivery of service. The Department of Mental Health and Developmental Disabilities (DMHDD) is Tennessee's recipient of the federal monies, and is responsible for the implementation and oversight of the program.

Lea Haynie, PATH program specialist in the DMHDD's Division of Mental Health Services, stressed that the PATH program provides the critical link to mental health and other necessary services for homeless, mentally ill persons.

"PATH workers make contact with individuals that most people in society tend to overlook. They take the time to get to know them, to find out what they need to improve their lives and to get off the streets," Haynie said. "The PATH program is specifically geared toward identifying and serving a vulnerable population that would not ordinarily receive services unless they were accessed through more costly means, such as the criminal justice system or emergency services."

The DMHDD contracts with seven separate agencies to spearhead the program in eight community locations. These community-based organizations are required to provide outreach, screening and diagnosis and habilitation and rehabilitation. They also provide community mental health, addiction treatment (for people with co-occurring addictive and mental disorders), case management, residential supervision and limited housing services for homeless people with serious mental disorders.

Homeless persons and those at imminent risk of homelessness with serious mental disorders or co-occurring addictive and mental disorders are targeted for the aid. The 12-year-old program usually leads an estimated 1100 homeless adults each year to the mental health care they need.

Homeless Outreach

Administering the aid are countless caseworkers who interact day in and day out with the homeless. The caseworkers are stationed throughout the state and are trained to enter the communities and find those in need.

Among those receiving aid nationally, nearly 92 percent are between the ages of 18 and 64. An estimated 43 percent have schizophrenia and other psychotic disorders and 36 percent had affective disorders such as depression. And, more than half of all those served were male.

For more information on the PATH program, contact Lea Haynie, Coordinator of the PATH program at (615) 532-6767.

Children and Youth Homeless Outreach

It was 4:00 p.m. on a Friday when Tammy Jones received a call. It was the local domestic violence shelter wanting her to speak with a family that was staying at the shelter. The mother and her two children were staying there because the father had abused them. When Jones spoke with the mother and two children, all were scared and confused. The mother stated that she didn't know how she was going to take care of her two children. The children told Jones, they were afraid of their father and one said "I would rather go to a foster home than go back home." Homelessness was now a reality for this mother and her two sons.

As an outreach worker for "The Children and Youth Homeless Outreach Program," Jones's responsibility is to provide outreach case management for homeless families in order to keep the family intact. Those services may include assisting the parents in securing needed mental health services for their children, as well as for themselves or filling out paperwork for items such as a replacement Social Security card or TennCare service.

"It is so important to try to provide some stability for the children and family during this difficult time," Jones said.

Helping secure housing, mental health treatment and getting those in need to school-related meetings are but a few of the services performed by outreach workers in six sites throughout Tennessee. In fact, 351 families (which included 538 children) were given assistance in 2000.

Reaching homeless children and their families is a priority for the Department of Mental Health and Developmental Disabilities (DMHDD). Begun four years ago, The Children and Youth Homeless Outreach Program is a key tool in achieving the department's goal.

Kim Rush, mental health specialist III for the DMHDD, said that reestablishing the families and providing stability for the children is first and foremost.

"The outreach workers strive to meet every required need of the children and family to allow them to get back on their feet," Rush said. "We've had many success stories, in the past, and foresee many more."

Clockwise from top: A training session for caseworkers.

- Brian Huskey, a homeless outreach worker for the Metropolitan Development and Housing Agency (far left) and Kurt Moss, Homeless Team Leader for the Mental Health Cooperative, (standing at right) talk to three homeless adults trying to ascertain whether they qualify for any mental health care covered under the adult PATH program. Homeless adults must have a bona fide mental illness before help can be given.

- It's never a good situation when a child, let alone an entire family is homeless. Here, a child passes the time at a playground.

When Lost i

by Judy Regan, M.D.

The world appears a jumble of disorganized thoughts. Sunlight's bright glory is but a pinprick in a heavily shrouded existence. Pain and problems are surrounding your every step. What can you do? Where can you go to ease the pain? Isn't there anyone that can help?

Suicides occur when individuals regard their lives as having unacceptable value and death is preferable. The value of a person's own life is assigned by the individual through a process of self evaluation that is a result of his own self assessments as well as the appraisals of others. How does a person decide that death is desirable? This varies from individual to individual. However, there are some known facts about suicide that will be addressed in depth below.

National Statistics

Suicide is a national health concern as shown by the following:

- Suicide is the 11th leading cause of all deaths in the United States.
- Families of those who commit suicide create a population of over 4 million mourners in the U.S.
- Suicides are increasing for young persons, African American young men and adults over 65.
- Suicide attempts are estimated to exceed 750,000 annually.
- 95% of those who commit or attempt suicide have a diagnosed mental illness.

Warning Signs

Some of the warning signs that can be seen with suicidal individuals are:

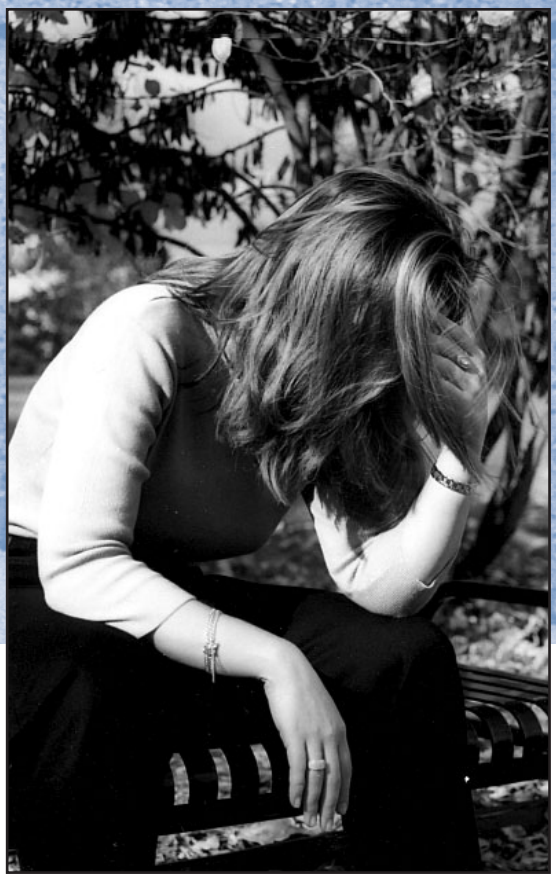
- Changes in appearance–less neat, less clean.
- Changes in behavior–sleeps or eats more or less than usual, is irritable or withdrawn or very sad.
- Changes in activities–dropping out of previously liked activities, increased substance abuse.
- Talking about death or about being with loved ones who have died.
- Making final arrangements.
- Distancing themselves from loved ones.

Factors Associated with Suicide Risks

The most predictive items used by clinicians when assessing a patient that are associated with suicide risk are:

- Age 45 and older
- Alcohol dependence
- Violence
- Prior suicidal behavior
- Male
- Unwilling to accept help

n the Silence of One's Heart...



- Longer than usual duration of depression
- Prior inpatient psychiatric treatment
- Recent loss or separation
- Depression
- Loss of physical health
- Unemployed or retired
- Single, widowed or divorced

Prevention and Treatment

Most of the suicides are currently preventable, but there is still a need for the development of more effective suicide prevention programs. Suicide prevention has to do with:

- Individuals helping people see that suicide is not the only choice and getting the help needed. This is done by individuals being aware of those things that lead to an increased risk of suicide.
- Ensuring the development, accessibility and affordability of mental health services, to enable all persons at risk to obtain treatment without fear of any stigma.
- Establishing national organizations such as SPAN to work toward the prevention of suicide. (i.e., SPAN, a non-profit organization, is dedicated to the creation of an effective national suicide prevention strategy. SPAN links the energy of those bereaved by suicide with the expertise of leaders in science, business, government and public service to achieve the goal of significantly reducing the national rate of suicide.)
- Establishing state organizations such as Regional Suicide Prevention Networks to assist states in implementing strategies to prevent suicide.
- Establishing community organizations such as prevention centers, crisis listening posts and suicide telephone hotlines that are clear attempts to intervene and diminish the isolation, withdrawal and loneliness of suicidal individuals.

Summary

Remember most people who commit suicide or attempt suicide do not want to die. They want to end the pain they are in. With help, most people can find a different way to end the pain. Suicide prevention has to do with helping a person see that suicide is not the only choice, that there are other ways to end the pain and solve the problems. Suicide prevention has to do with everyone being aware of the statistics, risk factors, warning signs and treatment options in order to get people the help they need.

... Hope Is Only a Phone Call Away

By Jason Levkulich

Reality can be very trying. Under a heavy emotional burden, even the strongest person can, at times, feel like there is no where to turn...no one to listen.

It's times like these that anyone's voice and reassuring words can make the difference between life and death.

"Sometimes, they are so distraught, they can't see any other options," said Dorothea Severino, a volunteer counselor at Nashville's Crisis Intervention Center. "When they call, it's a critical juncture in their life. They find talking to someone helps them get past that point."

When it comes to critical junctures, Severino is no stranger. In her late teens, Severino noticed her eyesight getting noticeably worse. After a visit to the doctor, she found out that she had retinitis pigmentosa, a disease that gradually destroys peripheral vision. It soon began affecting her ability to read, and her eyes increasingly had difficulty adjusting to various lighting situations.

At 35 she could no longer read. Around this time, Severino had also developed macular degeneration, which destroyed her central vision. By 40, she could no longer go shopping on her own. Today, she is totally blind.

So when callers tell of pain, anger and disappointment, Severino can relate. But, she uses her experiences to help diffuse any situations her callers might have. She has conquered her fears, and now works towards calming others.

At the Crisis Intervention Center, no two days are the same. Poised at phones, the center's counselors are ready to help give information, solace or a word of encouragement to the troubled, seven days a week – 365 days a year.

The calls can be any kind, from fantasy to domestic violence to suicide. Most of the time, counselors spend between 15–20 minutes talking to a caller. Often, only referral information is given. Very few actually hang up leaving the counselors worried about a life-threatening occasion.

"We're taught to assess the situation and respond accordingly," Severino said. "If the conversation remains serious, we'll stay on the lines as long as it takes. My longest call was two hours in length, but it ended with the person calming down and assuring me she was in a much better frame of mind."

All calls to the crisis center are confidential. While the counselors ask for names and addresses, in case emergency care is needed, technology such as caller ID and line tracing is used only in dire predicaments.

"We don't always know if the people actually use our referrals and get help or if they truly commit suicide," Severino said. "But by the end of each conversation we can usually tell by the caller's tone of voice and the way they respond to us. We, also, offer a follow up call to double check on them."

The crisis center workers try not to find solutions for the callers, but instead offer names, addresses and phone numbers of organizations that can aid the callers.

"We try not to come up with solutions," Severino said. "They'll start to depend on someone other than themselves to fix their problems. We try to reassure and calm them. Then, once we have their trust, we can point them in the right direction."

"Call Me. We'll talk"

Dorothea Severino, a seven and a half-year veteran of the Crisis Intervention Center, provides a caller with information.

Unlike other counselors, Severino is blind and uses the help of a brailler and special software to help her diffuse situations or disseminate information to callers.

The center, accredited by the American Society of Suicidology, uses around 60 volunteers to staff the phones. Each person is given intense training (32 classroom hours and eight hours on the phones with a buddy) before going solo. Various mental health and committee screenings are also given to select only the very best volunteers.

For more information about becoming a volunteer, contact volunteer services at (615) 244-7444.

History of the Tennessee Suicide Prevention Strategy

On April 23, 1999 regional workshops were held across the state to develop "The Strategy for Suicide Prevention in Tennessee" as a response to the 15 recommendations presented in the Surgeon General's "Call to Action." In it he proposed a nationwide, collaborative effort to reduce suicidal behaviors and to prevent premature death due to suicide across the life span.

These strategies were then submitted for consideration at the statewide Tennessee Suicide Prevention Conference on October 7-8, 1999, in Nashville, Tenn. The Tennessee Strategy for Suicide Prevention was accepted and adopted. In September 2000, a statewide coordinator was hired to implement the strategies across the state.

On September 26, 2001 the Advisory Council met and agreed this initiative shall be called "Tennessee Suicide Prevention Network." At this time, the Tennessee Suicide Prevention Network Director is Scott Ridgway.

A proclamation from Governor Don Sundquist declared May 28, 2002 "Suicide Prevention Awareness Day" in Tennessee.

For more information regarding the network, please contact Scott Ridgway at (615)298-3359.